STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013149	A. BUILDING: _____ B. WING _____	06/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING VIEW NURSING AND REHABILITATION CEI	475 NORTH NILES AVENUE SOUTH BEND, IN 46617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for an Initial State Residential Licensure Survey. Survey dates: June 6, 7, and 10, 2013 Facility Number: 013149 Provider Number: 013149 AIM Number: N/A Survey Team: Shauna Carlson, RN - TC Julie Baumgartner, RN Shelly Vice, RN Census Bed Type: Residential: 35 Census Payor Type: Other: 35 Residential Sample: 8 Morning View Nursing and Rehabilitation was found to be in compliance with 410 IAC 16.2 in regard to the Initial State Residential Licensure Survey. Quality Review 06/10/13 by Lisa McColly	R 000		